Clinically Integrated Network

Coordinated Care to Increase Quality and Reduce Cost

Extracted Sections of Proposed Approach Presented to MCAC on February 28, 2018

Tamara Smith
President and CEO
District of Columbia Primary Care Association (DCPCA)
tsmith@dcpca.org
(202) 552-2301

Table of Contents

NOTE: The sections below represent *extracted* paragraphs from the Network's full draft proposal.

INTRODUCTION

As the healthcare landscape shifts to value-based payment, providers are developing new ways to coordinate care in pursuit of shared goals. In pursuit of greater quality and lower cost, seven DC-based community health centers and the DC Primary Care Association (DCPCA) have come together to establish a new model of delivering care: the formation of a Clinically Integrated Network ("the Network").

- Seven community health centers, each designated Federally Qualified Health Centers (FQHCs), have a long history of providing comprehensive primary care services to low-income and underserved District residents: Bread for the City, Community of Hope, Family and Medical Counseling Services, La Clínica del Pueblo, Mary's Center, Unity Health Care, and Whitman-Walker Health.
- DCPCA is a non-profit healthcare equity organization that provides health information technology, quality improvement, and advocacy for community health centers throughout DC.

The Network aims to increase quality and decrease cost through measurable impact on low acuity non-emergent (LANE) emergency room, avoidable hospitalization, and avoidable hospital readmissions. The core interventions of the Network's strategy include:

- **Health information technology and data analytics:** Optimize the use of electronic health records in patient care; and Utilize population health analytics to drive care strategies and network performance.
- **Hospital-based transition of care**: Nurse-led transition of care program for priority group focusing on discharge follow-up with PCP and specialists, transmission of discharge plan, home health coordination, and medication reconciliation.
- **Expanded clinic access:** 24/7 nurse, triage, coordinated access to same and next day appointments, and mass patient education campaign on primary care and network services
- **Standardized care management for complex health and social needs:** Clinic-based teams that implement standardized assessment and care plan approach.

Since 2016, a Network project work group with designated leads from each health center have been working with DCPCA as well as subject matter experts from Optum and Health Management Associates (HMA) to develop the Network's model and strategies. Project partners have agreed to share accountability for the quality, cost, and care of a defined population of patients. The Network will seek to contract with Medicaid MCOs on a PMPM and shared savings basis to support program operations. Further the Network will leverage funding from private and governmental entities. The Network would have a formal legal structure (with clinical and administrative oversight systems) allowing it to receive and distribute payments for shared savings. As of January 2018, the Board and governance structure has been established and bylaws and participation agreements have been finalized with each health center.

GOALS AND OBJECTIVES

The goals for the Network are to increase quality and decrease cost, therefore improving the value of care provided.

To achieve this goal, the Network has four primary objectives:

- Reduce disparities in health outcomes and improve the wellbeing of our patients using an integrated care approach;
- Improve patient engagement in care by reducing barriers and gaps in services through collaboration;
- Build shared, actionable data to guide care and improve performance; and
- Support a culture of accountability, improvement, and effectiveness.

The Network will create interventions that are trackable by specific metrics and for which baseline data is available, aimed at the three areas of concern for District patients and stakeholders:

- Reduce low acuity non-emergent (LANE) emergency room visits
- Reduce avoidable hospitalization
- Reduce avoidable hospital readmissions (30-days)

OVERVIEW OF THE NETWORK

The Network is uniquely positioned to address the needs of District's residents that have the highest healthcare needs. FQHCs are at the core of the safety net system in the District, serving communities with high proportions of low-income residents: "90-95% of their [FQHCs] patients live in low-income households earning less than 200% of the federal poverty level (FPL)... In many of DC's wards, FQHCs provide care to more than 50% of the ward's population, and more than 80% of a ward's low-income population."[1]

Combining the services, partnerships, and practice culture of seven FQHCs, the Network will establish a continuum of care that addresses the diverse needs of each patient. Together, we provide comprehensive primary care at over 45 locations throughout the city.

As longstanding primary care providers in the city, the FQHC members of this Network collectively and individually bring a host of collaborations and partnerships. First and foremost, the Network has historical relationships with DC neighborhoods, communities, and families. As all of our Boards of Directors are made up of a majority of patients, our health centers are guided by the very patients they serve. Beyond the patient relationships, the Network forms a web of services with links to many community-based housing and social services partners, hospitals and other medical entities, and city agencies.

Overview of DCPCA

Founded in 1996, the DC Primary Care Association (DCPCA) is a non-profit healthcare equity organization dedicated to improving the health of DC's vulnerable residents by ensuring access to high quality primary health care–regardless of an ability to pay. DCPCA's mission is to facilitate the development and sustainability of an effective, integrated health care system in the District that guarantees access to primary care and eliminates disparities in health outcomes. DCPCA enhances and leverages resources to expand, strengthen, and improve primary health care services for District residents. DCPCA's membership includes 15 community health centers, with nearly 50 health care delivery sites, primarily in medically underserved communities, that serve approximately 200,000 residents each year from the District and surrounding communities.

[1] *DC DOH Health Systems Report.*

OVERVIEW OF STRATEGY

The clinically integrated network is a group of providers who collaboratively make a commitment to improve the quality and efficient of care for the patients they serve. The Network will provide a structure, methodology, and resources to support coordinated care to avoid hospitalizations and readmissions, minimize duplication of services, and address gaps in care. Futher, the Network will support sharing of best practices and standardized care.

The Network will open up new sources of data to inform and influence care decisions. This includes enhanced health information technology and exchange to support shared medical and care plan information between Network partners and directly with hospitals, specialty care, and other care entities

Through utilization of quality improvement techniques and data-driven program development, the Network will continuously measure our activities and adjust our interventions to drive toward positive impact and change. We will share lessons learned and spread successes across the Network, as well as pull from our broad array of experts in various fields. The interventions described in this proposal are just the beginning. We expect to tailor, tweak, and invent new strategies along the way to meet our goals.

Core Interventions

Figure 1. The Network's Core Interventions

Target	Reduce LANE ER visits	Reduce hospital re-admissions	Reduce hospital admissions
Primary Interventions	**Health Information Technology and Analytics:** • Optimize the use of electronic health records in patient care; and • Utilize population health analytics to drive care strategies and network performance.		
	Expanded clinic access: 24/7 nurse triage line, coordinated access to same and next day appointments, and patient education campaign on primary care and network services, and practice transformation to increase the level of care provided at some of our sites	**Hospital-based transition of care:** nurse-led transition of care program for priority group focusing on discharge follow-up with PCP and specialists, transmission of discharge plan, home health coordination, and medication reconciliation.	**Standardized care management for complex health and social needs**: Clinic-based teams that implement standardized assessment and care plan approach. This includes a Housing-to-Health project targeted to high utilizers with intervention-sensitive social determinants.

Overview of Hospital-Based Transition of Care Intervention

According to a 2003 study by Forster et al., almost 20 percent of hospitalized patients experience an adverse event within three weeks of discharge – 75 percent of these complications, including adverse drug events, hospital-acquired infections, and procedural complications, could have been avoided or minimized with improved hospital discharge and post-hospital care. The Agency for Healthcare Research and Quality has identified key challenges related to hospital discharge that contribute to re-hospitalizations.

Through the Transitions of Care (TOC) intervention, the Network seeks to address these challenges, which include:

1) discontinuity between inpatient and outpatient providers, including lack of timely and complete discharge information,

2) changes or discrepancies in medication lists before and after a hospital stay,

3) inadequate preparation for discharge, including inadequate patient education, and

4) burden of care assumed by patients and families after discharge[2].

Each of these key challenges point to the critical role primary care providers must play in managing transitions of care.

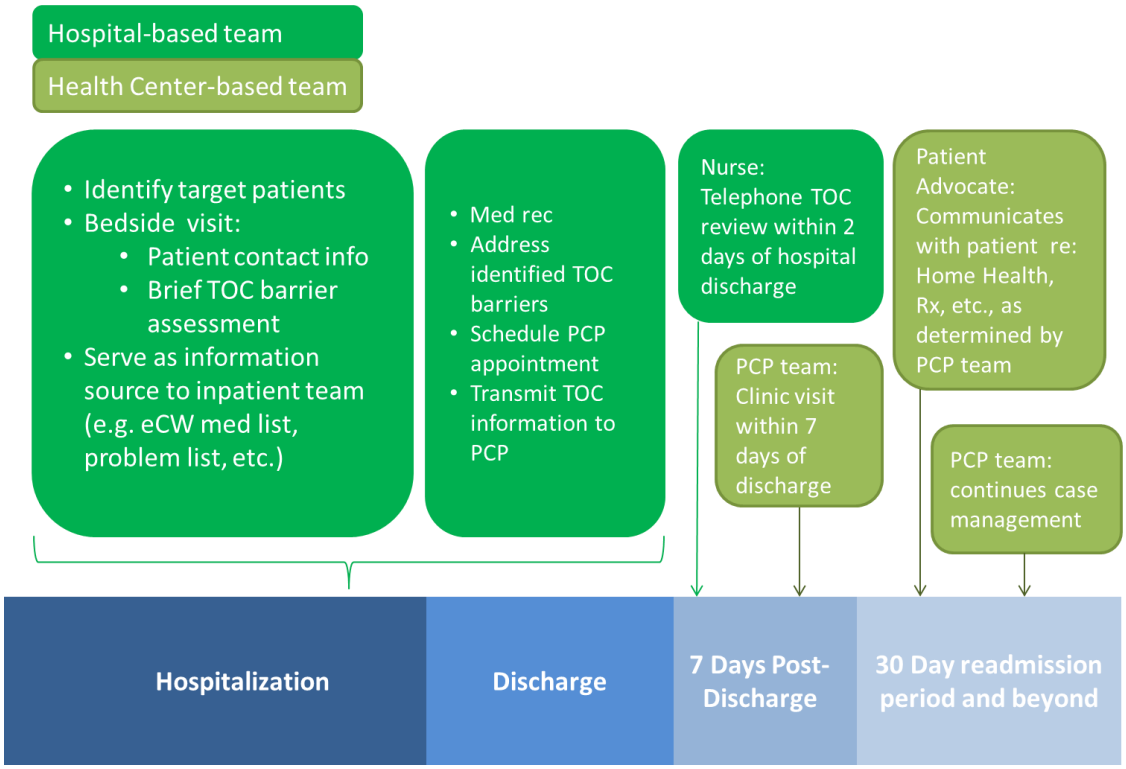
The Network's targeted TOC approach is a short-term, evidence-based intervention for patients at high risk of experiencing a readmission to the hospital within 30 days of discharge. Rather than duplicating services provided by hospital discharge planners, the Network proposes a collaborative model that augments existing efforts. A RN-led hospital-based team will serve as a bridge between hospitalization and primary care and will reduce 30-day all cause readmission rates by focusing on timely, bi-directional transmission of relevant clinical data, assessment and remediation of key social-determinant barriers, and strong handoffs that facilitate timely primary care follow-up and connection to care management resources. In most instances, the intervention will span 3-7 days, although with the potential to extend up to 30 days post-discharge for certain groups, in a later phase of implementation.

This short-term intervention begins when an eligible patient is admitted to a participating hospital, and ends upon completion of a timely follow-up appointment with the PCP, defined as within 7 days of discharge (the 7-Day Pledge). In instances in which the patient is already enrolled in care management, as with My Health GPS, a shorter intervention with rapid hand off to clinic-based care management staff will maximize efficiency. In later phases of implementation, the 7-day intervention timeframe lends itself to extension through the 30-day readmission window for high-need patients without existing primary care or care management connections.

Figure 2 lays out the activities of the TOC team as a patient progresses through the intervention window.

[2] *IDEAL Discharge Planning Implementation Handbook, AHRQ, pg. 10*

Figure 2. Transitions of Care Team



GOVERNANCE

The Network has been incorporated as a nonprofit entity. The business and the affairs of the Corporation shall be directed, controlled and managed by the Board, which shall be vested with the overall responsibility and authority for the operation of the Corporation. Each FQHC that enters into a Participating Center Agreement with the Corporation shall be represented by one (1) directorship on the Board. The Network Board has established standing committees, including, but not limited to, an Audit and Compliance Committee, a Finance Committee, a Data Workgruop, and a Clinical Operations and Clinical Integration Committee. Each standing committee shall be compromised of at least one Director.

The Network will provide the following to each FQHC:

- reports and data regarding the overall performance of the Network and the individual performance of the FQHC;
- administrative support and structure to operate and manage the Network;
- technical assistance in performance improvement;
- opportunities to participate in practice enhancement activities;
- development of educational materials for patients and providers;
- marketing of programs associated with the Network;
- management of shared savings and other Network incentive program fund payments, according to the allocations, standards and requirements approved by the Network's Board of Directors.